



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Shannon Clinic

Respondent Name

Service Lloyds Insurance Co

MFDR Tracking Number

M4-16-1757-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

February 23, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We respectfully request our charges for (claimant) be reprocessed for payment as Shannon Clinic has provided all documentation that we meet timely filing guidelines under House Bill 1005 Rule 133.20 Section 408.0272."

Amount in Dispute: \$117.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Corvel processed the claim based on the information provided by the Requestor on both the original bill and the request for reconsideration."

Response Submitted by: Corvel Healthcare Corporation, 10000 North Central Expressway, Suite 300, Dallas, Texas 75231

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: September 10, 2015, 99213, \$117.00, \$109.51

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
3. 28 Texas Administrative Code §102.4 establishes rules for non-Commission communications.
4. 28 Texas Administrative Code §134.203 sets out reimbursement guidelines for professional medical

services.

5. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
6. Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical claim.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 29 – the time limit for filing claim/bill has expired

### **Issues**

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?
3. What is the applicable rule pertaining to reimbursement?

### **Findings**

1. The insurance carrier denied the disputed services with claim adjustment reason codes: 29 – “The time limit for filing has expired.” 28 Texas Administrative Code §133.20(b) requires that, except as provided in Texas Labor Code §408.0272, “a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.” Texas Labor Code §408.0272(b) provides that:

Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:

- (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:
  - (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;
  - (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or
  - (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title; or
- (2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

Documentation was found to support that the requestor submitted a claim to BlueCross BlueShield of Texas on date 09/18/2015. For that reason, the health care provider submitted the medical bill within 95 days after the date the disputed services were provided or September 10, 2015.

2. Texas Labor Code §408.027(a) states that “Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment.” 28 Texas Administrative Code §102.4(h) states that:

Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:

- (1) the date received, if sent by fax, personal delivery or electronic transmission or,
- (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.

Review of the submitted information finds the following;

- Explanation of benefits from BlueCross BlueShield of Texas dated September 18, 2015 for date of service September 10, 2015, Proc/Mods – 99213.

- Statement from requestor, "We submitted claim directly to Corvel by fax on 11/24/15. They contacted us by telephone and stated we should send directly to Service Lloyds."
- Document titled, "Out of Network," Determination – "Approved" dated November 17, 2015.

The respondent states, "However, the fax number provided (866-738-0675) does not belong to Corvel;" The Division finds insufficient evidence was found to support the respondent did not receive information required by Texas Labor Code §408.0272(b) but rather, documentation to support that a medical bill was submitted within 95 days from the date the services were provided.

Consequently, the requestor has not forfeited the right to reimbursement due to untimely submission of the medical bill, pursuant to Texas Labor Code §408.027(a). The services in dispute will be reviewed per applicable rules and fee guidelines.

3. 28 Texas Administrative Code 134.203(c) states, (c)(1) states,  
To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

The maximum allowable reimbursement is calculated as follows:

$$(DWC \text{ Conversion Factor} / Medicare \text{ Conversion Factor}) \times Allowable = TX \text{ Fee MAR or}$$

$$(56.2 / 35.9335) \times 70.02 = \$109.51$$

The maximum allowable for the service in dispute is \$109.51. This amount is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$109.51.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$109.51 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

**Authorized Signature**

Signature	Medical Fee Dispute Resolution Officer	March 15, 2016 Date
-----------	--	------------------------

## ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**